# Physicians for Compassionate Care

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Affirming an ethic that all human life is inherently valuable


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TESTIMONY OF PHYSICIANS FOR COMPASSIONATE CARE
TO
SUBCOMMITTEE ON HEALTH AND ENVIRONMENT
COMMITTEE ON COMMERCE
U.S. HOUSE OF REPRESENTATIVES
MARCH 6, 1997

Physicians for Compassionate Care, an organization of Oregon doctors with more than 5 00 members, urges each member of the Subcommittee on Health end Environment to support legislation forbidding use of any federal funds for physician-assisted suicide or euthanasia. Such practices would place too many vulnerable citizens in harm's way. They would give control over treatment versus suicide dilemmas to healthcare bureaucracies and agencies. not to individual patients and their doctors. In this era of cost containment, funding assisted-suicide would place the government of the United States of America in an unnecessary conflict of interest. It would enhance already growing distrust between patients and the governmental and corporate agencies controlling medicine today. Individual doctm could not withstand pressures created by federal sanctioning and funding of assisted-suicide. These are not mere speculations about some hypothetical future. These are conclusions supported by established and disturbing new facts.

The proposed Oregon experiment in assisted-suicide and euthanasia has created chaos in our state. Since a doctor assisted-suicide initiative was narrowly passed in 1994, the law has been challenged as unconstitutional in federal court. This very day seven bills are before the Oregon legislature proposing to overturn this law. Out medical societies have been tom with strife. Since this initiative was passed, we have learned a great deal which has bearing on tbe questions before this Subcommittee today. Much of what we have learned is disturbing.

Shortly after passage of Oregon's assisted-suicide initiative, proponents announced that such procedures are often prolonged, grotesque, and inhumane. They now publicly declare that they are not satisfied with assisted-suicide, unless it is backed up by active euthanasia, that is, the doctor finishing the job with a lethal injection.

Studies from the Netherlands have revealed that once euthanasia is officially sanctioned by rules, procedures, exceptions to other laws, suicide increases many fold. It does not decrease when brought out in the open. Studies published in the New England Journal of Medicine, November 28.1996, reveal that a quarter of people euthanized by Dutch doctors have been killed without their consent. This is established fact, not speculation about what might happen in the future.

The desensitization of our culture to conditional killing is already expanding the practice of euthanasia. In San Francisco, between 1990 and 1995, AIDS doctors and their patients were subjected to intensive propaganda promoting suicide as dignified. In 1990, only 8% of the San Francisco AIDS doctors had participated in assisted-suicide or euthanasia. In 1995, that number had increased to over half the AIDS doctors (New England Journal of Medicine, February 6.1997). One doctor had personally participated

in mom than a hundred of these deaths. Clearly, sanctioning and promoting suicide has had an effect -- on both doctors and patients.

Two weeks after this report, the Center for Disease Control happily announced that new treatments for AIDS have dramatically lowered mortality rates nationwide, even though the number of new cases continues to rise. Meanwhile, many AIDS patients, who could have benefited from these new treatments, were "assisted" to their deaths by doctors they trusted, when hope was just around the comer. What about these patients? Sadly, these individuals were judged hopeless. Would legalizing euthanasia have protected them? No. In the Netherlands, 22% of AIDS patients who die. do so at the hands of their doctors.

Yet. proponents of assisted-suicide still claim sanctioning it can control it. While the rules and regulations have not worked in the Netherlands, safeguards are weaker, indeed, almost non-existent in the Oregon experiment. For example, proponents tout the protection of mental health consultation for those who request the hastening of their death. Yet euthanasia's backers know psychiatric consultation is not requited at all in our state's plan and that only about one third of depression is recognized by the average doctor. In fact, a recent study documented that 94% of psychiatrists arc not confident they can determine when depression is affecting judgment about assisted-suicide requests (American Journal of Psychiatry, November, 1996).

Some proponents are striving to create new angles to reassure nervous voters and legislators. Dr. Peter Goodwin one of the Oregon measure'8 sponsors, claimed that "the rick of lawsuits would be far too great for doctors and health care organizations to participate in anything unethical" (Oregonian, March 2, 1997), when in fact this state's Death with Dignity Act forbids lawsuits about assisted-suicide and even prohibits public

scrutiny of the practice. Does the government of the United State8 of America want to fund such drastic new procedures with no oversight possible and with no legal recourse available to patients and their families?

The extent of managed and capitated care problems bas only begun to come to light. In capitated care, doctors and the organizations which increasingly control them cm increase profits by Providing less service to enrollees. Money can be saved by withholding care or not providing it at all.

As an example, in January, 1996, Tiie magazine told tbe story of a California woman with a life threatening illness who was denied treatment, because she was a managed care patient. The company considered the available treatment futile. The patient bad no choice. When she returned to the same institution claiming to be a fee for service Patient, she was offered the very same treatment she had just been denied. Now, it was no longer futile, but reasonable. Now, she bad a choice. While many managed care organizations strive to minimize potential abuses, won't organizations, currently denying treatments to enhance profits, also preferentially encourage assisted-suicide? They can do so merely by considering treatment futile. Assisted-suicide is clearly the cheapest option. Assisted-suicide and euthanasia give control to large health care bureaucracies and governmental agencies, not to the individual doctor and patient, as initially claimed.

Our state uses federal Medicare and Medicaid dollars to fund the Oregon Health Plan, which rations medical services through capitated care plans. Shortly after the Death with Dignity Act passed, Oregon's Medicaid director was reported in the Statesman Journal (Dec. 1, 1994) as saying that assisted-suicide would be a covered service under the "comfort care" category. Because of the furor over this issue at a time when funding for other treatments was being cut, tbe actual scheduling of assisted-suicide in the Oregon

Health Plan has been postponed. Nevertheless, as it now stands, if the law is not overturned, Oregon's suicides can be funded with federal dollars.

Does the government of the United States of America want to fund a practice, in a single state, which reduces costs by replacing treatment with suicide? Dow this Subcommittee wish to recommend funding a practice for which there are few or no safeguards, for which public scrutiny is forbidden by law, and for which patients and families are allowed no legal recourse in the event of negligent or unethical behavior? Does this Subcommittee wish to contribute to the deaths of trusting patients for whom hope might be just around tbc comer, as it was for AIDS patients in San Francisco who are now dead?

Funding assisted-suicide or euthanasia is too dangerous. We urge you to disallow any such use of federal dollars.

Respectfully submitted,

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